Health Care Financing Program Statistics

National Annual Medicaid Statistics: Fiscal Years 1973 through 1979

Published by the Health Care Financing Administration

Health Care Financing Program Statistics

The Health Care Financing Administration was established to combine health financing and quality assurance programs into a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, and a variety of health care quality assurance programs. The mission of the Health Care Financing Administration is to promote the timely and economic delivery of appropriate, quality health care to its beneficiaries — approximately 49 million of the nation's aged, disabled, and poor.

HCFA's Office of Research and Demonstrations (ORD) conducts studies and projects that demonstrate and evaluate optional reimbursement, coverage, eligibility, and management alternatives to the present Federal programs. ORD also assesses the impact of HCFA programs on health care costs, program expenditures, beneficiary access to services, health care providers, and the health care industry.

Medicaid *Program Statistics* report data on Medicaid recipients, eligibility, payments, services, and utilization by State and by total program. Medicaid *Program Statistics* are generated from reports submitted by each Medicaid jurisdiction at various intervals throughout the year. In FY 1982, Medicaid Statistics will be compiled and published in annual reports. We will also summarize Medicaid data in the *Health Care Financing Review* as it becomes available.

National Annual Medicaid Statistics:

Fiscal Years 1973 Through 1979

Prepared by Donald N. Muse

Published by
Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations

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Note to Readers

The appendices to this report are over 500 pages long. In the interest of economy, they are available only upon request.

Appendices

Appendix A. National Annual Medicaid Statistics: Fiscal Year 1977

Appendix B. National Annual Medicaid Statistics: Fiscal Year 1978

Appendix C. National Annual Medicaid Statistics: Fiscal Year 1979

Appendix D. Summary of the Medicaid Program: Services, Eligibility and Reimbursements

Appendix E. Annual Medicaid Statistics Report: SRS-NCSS-2082

Appendix F. Monthly Medicaid Statistics Report: SRS-NCSS-120

Appendix G. Special Adjustment Procedures for New York and Pennsylvania Data: Fiscal Year 1973 Through Fiscal Year 1979

1.0 Introduction

1.1 Purpose

This publication is an annual report containing a descriptive overview of Medicaid (Title XIX of the Social Security Act) trend data on medical assistance payments and recipients of services for Fiscal Years 1973 through 1979 and detailed data for Fiscal Years 1977 through 1979. The primary purpose of presenting these statistics is to provide State, regional, and national statistical data to program managers and researchers in order that they may monitor the Medicaid program. Thus, the intent is to display national statistics, not to provide detailed analysis. Other data and analyses are available in the Health Care Financing Administration's (HCFA) publications *National Monthly Medicaid Statistics* and *The Medicare and Medicaid Databook*.[1]

1.2 Organization of the Report

The report begins with a brief description of the Medicaid program as it relates to this report (Section 1.3), an explanation of how the data are collected (Section 1.4), and highlights of the report (Section 1.5). National summary data are then presented in each of the following areas:

- Recipients of Services (Section 2.0);
- Payments (Section 3.0);
- Comparisons between Recipient and Payment Distributions and Average Payments Per Recipient (Section 4.0);
- Use of Services by Recipients (Section 5.0); and
- Special Topics (Section 6.0).

In each of these sections, the data for FY 1979 are first presented and discussed, and then trends from FY 1973 to FY 1979 are presented and discussed. Fiscal Year 1973 was selected as the most appropriate year to begin examining data trends for a number of reasons. First, FY 1973 was the first full year in which the data collection form (SRS-NCSS-2082) was implemented. This form contains most of the data used in this publication. Second, FY 1973 marks the beginning of the implementation of the Medicaid Management Information System (MMIS). The MMIS represented a major step forward in the management and information capabilities of the Medicaid program, especially the ability of the Medicaid jurisdictions to generate statistical reports. Third, this was the first year of fiscal, and not calendar year, reporting. Finally, data from before FY 1973 can best be examined only on a State by State basis. Specifically, FY 1965 to FY 1972 was a period in which States began their Medicaid programs. Hence, data trends are confounded with program start-up problems before FY 1973. Sixty-eight tables, containing annual Medicaid statistics on recipients and payments for services, are presented for FY 1977 (Appendix A), FY 1978 (Appendix B), and FY 1979 (Appendix C). These appendices comprise the bulk of this report.

1.3 Medicaid Program as Related to Statistical Reporting[2]

Medicaid is funded jointly by the States and the Federal government to provide medical assistance to specified groups of needy individuals. The program is administered by 54 jurisdictions including 49 States, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and a separate State agency for blind recipients in Massachusetts.[3] Arizona has not implemented a Title XIX program. More than 98 percent of Medicaid payments are made out of Medicaid funds to providers (vendors) of medical services, either directly by the State Medicaid agency or by the State's fiscal agent as the direct result of claims filed by the provider after services are rendered. The remaining 2 percent of Medicaid payments are expended as premium payments to HCFA for Medicare Part B coverage and *per capita* payments to health insuring agencies and health maintenance organizations (HMOs).

1.3.1 Payments

All payment data in this publication represent the sum of Federal, State, and local dollars for Medicaid services. Statistical tables cover only medical vendor payments and not premiums paid to Medicare Part B or HMOs. Payments to Medicare Part B and HMOs appear only in Section 3.5 of this report.

Medical vendor payments encompass 15 distinct types of services which can be grouped into inpatient and outpatient care. Inpatient care includes: general hospital inpatient services; mental hospital inpatient services; skilled nursing facility services; intermediate care facility services in institutions for the mentally retarded; and intermediate care facility services in all other institutions. Outpatient care includes: physicians' services; dental services; other practitioners' services; outpatient hospital services; clinic services; laboratory and radiological services; home health services; prescribed drugs; family planning services; and other care. General assistance statistics represent medical assistance payments by States that are not matched by the Federal government. These data are not provided in the detailed State tables and appear only in Section 6.4.

[1] These and other statistical publications can be obtained from ORD Publications, 1-E-9 Oak Meadows Building, 6340 Security Boulevard, Baltimore, Maryland 21207.

[2] A more detailed summary of Medicaid program services, eligibility, and reimbursement can be found in Appendix D and "The Medicare and Medicaid Data Book–1981."

[3] The Northern Mariana Islands became the 55th Medicaid jurisdiction in FY 1980, a time period not covered by this report.

1.3.2 Eligibility

The following table displays the 12 different groups into which eligible individuals are classified for programmatic and statistical purposes.

Relationship of Basis of Eligibility and Maintenance Assistance Status

Basis of Eligibility	Maintenance Assistance Status: Money Payment Authorized ("Cash Assistance")	Maintenance Assistance Status: Money Payment Not Authorized ("Medicaid Only")
Age 65 and Over	Group 1	Group 2
Blindness	Group 3	Group 4
Permanent and Total Disability	Group 5	Group 6
Dependent Children Under Age 21	Group 7	Group 8
Adults in Families With Dependent Children	Group 9	Group 10
Other Title XIX	Not applicable[1]	Group 11
State Only	Not applicable	Group 12

[1] This group existed in small numbers prior to FY 1975. However, it was phased out by the 1972 amendments to Title XIX of the Social Security Act.

The five main eligibility groups are: age 65 and over; blind; permanently and totally disabled; children in families with dependent children under 21; and adults in families with dependent children under 21 (Groups 1 through 10).[4] These eligibility groups are a result of the direct administrative linkage of Medicaid to the Aid to Families with Dependent Children (AFDC) and the Supplementary Security Income (SSI) cash assistance programs. Specifically, all AFDC and SSI recipients are entitled to Medicaid. In addition, some States have exercised the option of extending Medicaid coverage to other needy persons who do not fall into any of the above categories. Such persons are classified as "Other Title XIX" eligibles (Group 11). Finally, several States cover certain individuals not eligible for matching Federal Financial Participation solely out of State funds. In FY 1979 approximately 47 percent of the nation's poor, such as single persons and childless couples, who are not included in other eligibility groups, can receive medical assistance only as members of this group (Muse, 1980). These individuals are known as "State Only" eligibles (Group 12).

These 12 groups related directly to a number of other terms which describe the Medicaid recipients, especially those known as "medically needy" recipients. These are recipients who are eligible for Medicaid because: (1) they would receive cash assistance under Aid to Families with Dependent Children (AFDC) or Supplementary Security Income (SSI) except that their income or asset levels are above the cash assistance standard; and (2) their income (after subtracting medical expenses) falls below the program standard. Coverage of these persons is optional for the States. As of FY 1979, 34 Medicaid jurisdictions have medically needy programs. Medically needy recipients constitute approximately 75 percent of the Medicaid Only groups (2, 4, 6, 8, 10 and 11). The remaining 25 percent of the Medicaid Only recipients are recipients who are categorically eligible but who do not receive cash assistance.

[4] The title "permanently and totally disabled" is somewhat misleading in that eligibility for this group is obtainable for less than permanent and total disability. Also, the SSI programs became operational on January 1, 1974 regarding Medicaid.

1.3.3 Special Programs

State Medicaid programs must provide early and periodic screening, diagnosis, and treatment services (EPSDT) to all individuals who are eligible for Medicaid and are under 21 years of age. In addition to the Medicaid program, some States cover medical services beyond those provided for by Title XIX and, therefore, Federal matching funds are not available. The total payments for this General Assistance (sometimes referred to as "State Assistance") are included in Medicaid reporting to encompass the entire realm of medical assistance provided by States. Data on both of these special programs are contained in Section 6.0 of this report.

1.4 Source and Limitations of the Data

The information presented in this report comes from a compilation of the annual Medicaid reports submitted by the State Title XIX Medicaid agencies on the SRS-NCSS-2082 report (See Appendix E). The States obtain this information from their own Medicaid claims processing and payment operations. As a result, the data reported for a given fiscal year represent the bills paid during that year, not the services used during the year. The States are also required to submit monthly reports, SRS-NCSS-120 (see Appendix F), which provide details on the number of persons receiving medical services, the number of units of such services and the data on "State Only" Medicaid recipient payments presented in Section 6.0 of this report. The remainder of these monthly data are presented in the *National Monthly Medicaid Statistics* series.

The major source of data for the SRS-NCSS-2082 is the Medicaid Management Information Systems (MMIS) in the States. The General System Design (GSD) for these systems, completed and distributed by the Federal government to the States in 1972, allowed for considerable State variation in certain characteristics of the MMIS. This flexibility is congruent with the programmatic diversity existing across State programs. However, creating standardized reports out of systems employing non-standard coding, processing, and file structures obviously poses difficulties. The programmatic complications inherent in the Medicaid program itself compound these difficulties. For example, the county variations inherent in the New York State program lead to considerable problems in the creation of a State level report. As a consequence of these and other factors, in any fiscal year approximately five States do not file a SRS-NCSS-2082. Historically, missing State data have been estimated by using weighted linear extrapolation methods or by aggregating data from monthly reports. On several occasions, information supplied by the States in

subsequent years has been used to correct previous estimates of unreported data. Hence, data contained in this report may differ from those published previously. Examples of this situation are the New York and Pennsylvania adjustments described in Appendix G.

In spite of these limitations, the quality of national Medicaid data has improved since FY 1973 for a variety of reasons:

- Approximately $700 million dollars have been spent developing and improving certified MMIS systems;
- A number of Federally initiated efforts to integrate and to standardize coding systems have made cross-State comparisons more meaningful; and
- A Medicaid Quality Control (MQC) program which independently assesses the claims processing performance of the MMIS systems has been implemented.

Every effort has been made to improve Medicaid trend statistics over time. Some of the observed trends in this report may be a result of those improvements. However, as noted in several sections of the report, trends in the data in this report correspond closely to those observed in other data sources.

1.5 Highlights

Overview

Although the total number of Medicaid recipients increased only modestly between FY 1973 and 1979 (1.2 percent annually), total payments increased rapidly (15.1 percent annually), due primarily to two factors. The major contributor to the increased expenditures was the overall increase in the cost of medical services as measured by the medical component of the Consumer Price Index (up 9.7 percent annually) during this period. The second major contributor to increase in total Medicaid payments was the increasing proportion of (1) age 65 and over group recipients; and (2) permanently and totally disabled group recipients in the total recipient population. These two types of recipients are approximately 10 to 14 times more expensive per year than other recipient groups due primarily to their use of expensive long-term care and inpatient hospital services.

Recipients

- Total annual recipients of Medicaid increased from 20.0 million in FY 1973 to 24.7 million in FY 1976 and then fell to 21.5 million in FY 1979.
- The number of permanently and totally disabled recipients grew relatively more than any other recipient group as they increased from 1.9 million in FY 1973 to 2.6 million in FY 1979.
- Characteristics of recipients remained remarkably stable between FY 1973 and FY 1979 as the Medicaid recipients remained primarily female (65.3 percent) and white (53.0 percent), with the largest recipient age group being less than 21 years of age (47.6 percent).
- Recipients of outpatient hospital services increased from 27.0 percent to 34.9 percent of all recipients from FY 1973 to FY 1979.

Payments

- Total medical vendor payments increased from $8.6 billion in FY 1973 to $20.5 billion in FY 1979. This 133.0 percent increase is much greater than the 74.1 percent increase observed in the medical component of the Consumer Price Index over this same time period.
- Payments for services for the age 65 and over recipient group grew $4.4 billion dollars between FY 1973 and FY 1979. However, this group remained at approximately 37 percent of all Medicaid expenditures over this time period.
- Payments for services for permanently and totally disabled recipients grew from $2.0 billion to $6.1 billion between FY 1973 and FY 1979. This growth of $4.1 billion led to their increase from 19.3 percent of all Medicaid expenditures in FY 1973 to 29.8 percent of all expenditures by FY 1979. Clearly, this growth was at least in part a function of the 1972 amendments to Title XIX and Title XVI.
- Both in absolute and relative terms, long-term care services grew more rapidly than any other type of service between FY 1973 and FY 1979.

Recipients and Payments

- Two eligibility groups, (1) recipients age 65 and over not receiving cash assistance and (2) those permanently and totally disabled, together accounted for only 28.0 percent of all recipients, but consumed 67.1 percent of all payments in FY 1979. In contrast, the largest eligibility group, adults and children in families with dependent children, while constituting 63.5 percent of all recipients in FY 1979, accounted for only 27.9 percent of all payments.
- Average expenditures per recipient increased from $430 in FY 1973 to nearly $953 in FY 1979.
- Two of the payment groups not receiving cash assistance, recipients age 65 and over and those permanently and totally disabled, averaged approximately $4,300 and $4,000 per recipient, respectively. The average payments for these two groups were more than twice those of any other group.
- Health maintenance organization payments decreased as a percent of total Medicaid payments between FY 1973 and FY 1979 and by FY 1979 were only .6 percent of all Medicaid expenditures.

Use of Services by Recipients

- Although skilled nursing care use has decreased (−3.0 percent annually), intermediate care facility use, other than for the mentally retarded, has increased rapidly (10.3 percent annually). However, both of these services have seen an increase in the average number of days of care consumed per year per recipient.
- There has been a modest decrease in the average number of physician visits per recipient (from 4.7 per recipient in FY 1973 to 4.4 per recipient in FY 1979). This is in contrast to the average number of prescriptions per recipient, which increased from 10.8 per recipient in FY 1973 to 12.4 per recipient in FY 1979.

- The number of children receiving Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) has remained relatively unchanged since FY 1977, with 2.0 million children served annually.
- The Puerto Rican Medicaid program, due to its unusual nature (outlined in Section 6.2), has 6.6 percent of all Medicaid recipients but accounts for only .4 percent of all Medicaid payments.
- In contrast to the 15.1 percent annual growth rate observed in Federally matched payments, "State Only" payments, which reached $950.2 million in FY 1979, have increased only at a 3.0 percent annual rate of growth.

2.0 Recipients of Services

2.1 Recipients by Basis of Eligibility Groups and Maintenance Assistance Status

There were 21.5 million recipients of Medicaid services in FY 1979. Table A shows the distribution of these recipients by Basis of Eligibility and Maintenance Assistance Status.[5]

[5] A recipient is any individual enrolled in Medicaid who receives at least one covered medical service during the year.

The majority of all Title XIX recipients (74.4 percent) also receive cash assistance.[6] The majority of cash assistance recipients, and all Medicaid recipients, are adults (18.1 percent) and children (36.7 percent) in families with dependent children. Other than these groups only: (1) those 65 and over receiving cash assistance (9.7 percent); (2) other Title XIX recipients receiving Medicaid only (7.9 percent); and (3) recipients with permanent and total disability (9.3 percent) represent significant proportions of the total recipient population.[7]

2.2 Trends Over Time in Recipients

Table B shows the overall trends in the Medicaid recipient population by Basis of Eligibility groups for the years FY 1973 through FY 1979. The total number of recipients grew from 20.0 million in FY 1973 to a peak population of 24.7 million in FY 1976. Since FY 1976, the recipient population has decreased to 21.5 million in FY 1979, for a net growth of 1.5 million recipients (or a 1.2 percent annual compound rate of growth) since FY 1973.

[6] Due to receipt of late reports from two States, numbers in the appendices may differ slightly from those in some data tables in this publication.

[7] The concept of statistical significance does not apply to the discussions contained in this report since the statistics refer to population and not sample statistics. However, in several sections of this report subjective criteria have been selected for determining "significant" changes of a programmatic nature. This selection of significant criteria is non-statistical and has been done for the purpose of facilitating discussion of data differences and trends.

TABLE A
Recipients by Basis of Eligibility and Maintenance Assistance Status: Number and Percent of Total: Fiscal Year 1979

Basis of Eligibility	Total Recipients	Number (in millions)	
		Money Payment Authorized ("Cash Assistance")	Money Payment Not Authorized ("Medicaid Only")
Total	21.5	16.0	5.5
Age 65 and Over	3.4	2.1	1.3
Blindness	.1	.1	(Z)
Permanent and Total Disability	2.7	2.0	.6
Dependent Children under 21	9.1	7.9	1.2
Adults in Families with Dependent Children	4.6	3.9	.7
Other Title XIX	1.7	N/A	1.7
	Percent of Total[1]		
Total	100.0%	74.4%	25.6%
Age 65 and Over	15.7	9.7	6.0
Blindness	.5	.4	.1
Permanent and Total Disability	12.1	9.3	2.8
Dependent Children under 21	42.3	36.7	5.6
Adults in Families with Dependent Children	21.4	18.1	3.3
Other Title XIX	7.9	N/A	7.9

(Z) Indicates a number or percentage less than .05.
N/A = Not Applicable.
[1] Percentages and numbers may not total due to rounding.

TABLE B

Recipients by Basis of Eligibility and Maintenance Assistance Status: Number and Percent of Total by Fiscal Year: 1973–1979

Fiscal Year[1]	Total For Fiscal Year	Money Payments Authorized ("Cash Assistance")							Money Payments Not Authorized ("Medicaid Only")						
		Total	Age 65 and over	Blindness	Permanent and Total Disability	Dependent Children under 21	Adults in Families with Dependent Children	Other Title XIX Recipients	Total	Age 65 and over	Blindness	Permanent and Total Disability	Dependent Children under 21	Adults in Families with Dependent Children	Other Title XIX Recipients
						Number (in millions)									
1973	20.0	14.8	2.3	.1	1.5	7.1	3.7	.1	5.2	1.3	(Z)	.4	1.7	.5	1.4
1974	22.0	16.6	2.6	.1	1.9	8.0	3.9	.1	5.4	1.2	(Z)	.4	1.7	.6	1.4
1975	22.4	17.0	2.5	.1	1.8	8.5	4.1	N/A	5.5	1.2	(Z)	.5	1.3	.6	1.9
1976	24.7	18.4	2.5	.1	2.1	9.1	4.6	N/A	6.2	1.3	(Z)	.5	1.5	.6	2.2
1977	23.8	17.7	2.4	.1	2.2	8.7	4.3	N/A	6.1	1.2	(Z)	.5	1.4	.7	2.3
1978	23.1	17.3	2.2	.1	2.2	8.6	4.2	N/A	5.5	1.2	(Z)	.5	1.3	.7	2.1
1979	21.5	16.0	2.1	.1	2.0	7.9	3.9	N/A	5.6	1.3	(Z)	.6	1.2	.7	1.7
Change from FY 1973 to FY 1979	1.5	1.2	– .2	.0	.5	.8	.2	–.1	.4	.0	.0	.2	– .5	.2	.3
Annual Compound Rate of Growth	1.2%	1.3%	–1.5%	.0	4.9%	2.0%	.9%	N/A	1.2%	.0	.0	7.0%	–5.5%	5.8%	3.3%
						Percent of Total[1]									
1973	100.0%	74.0%	11.5%	.5%	7.5%	35.5%	18.5%	.5%	26.0%	6.5%	.2%	2.0%	8.5%	2.5%	7.0%
1974	100.0	75.4	11.8	.4	8.6	36.4	17.7	.5	24.5	5.5	.2	1.8	7.7	2.7	6.4
1975	100.0	75.9	11.2	.4	8.1	37.9	18.3	N/A	24.6	5.4	.2	2.2	5.8	2.7	8.1
1976	100.0	74.5	10.1	.4	8.5	36.8	18.6	N/A	25.1	5.3	.2	2.0	6.1	2.4	8.9
1977	100.0	74.4	10.1	.4	9.2	36.5	18.1	N/A	25.6	5.0	.1	2.1	5.9	2.9	9.7
1978	100.0	74.9	9.5	.4	9.5	37.2	18.2	N/A	25.5	5.2	.1	2.2	5.6	3.1	9.1
1979	100.0	74.4	9.7	.4	9.3	36.8	18.1	N/A	25.7	6.0	.1	2.8	5.6	3.3	7.9
Percent of Total Change from FY 1973 to FY 1979		.4	–1.8	–.1	1.8	1.3	–.4	–.5	–.3	–.5	–.1	+.8	–2.9	.8	.9

(Z) Indicates a number or percentage less than .05.
N/A = Not Applicable.
[1]Percentages and numbers may not total due to rounding.

The largest growth in absolute terms has been the approximate 1.2 million increase in cash assistance recipients. This growth is primarily a result of: (1) the increase in children in families with dependent children receiving cash assistance, which gained more than .8 million during these years (this group increased from 35.5 percent to 36.8 percent of the total recipients between FY 1973 and FY 1979); and (2) the increase of .7 million recipients who were permanently and totally disabled. The increase came from both cash assistance (up .5 million) and Medicaid only (up .2 million) recipients between FY 1973 and FY 1979.

As Section 3.0 shows, the growth of the permanently and totally disabled group is particularly important because it has a very high average expenditure per recipient and accounts for a disproportionate share of Medicaid expenditures.

In contrast to expanding groups, two groups decreased significantly during this period: (1) Medicaid-only children under 21 in families with dependent children (down .5 million children); and (2) cash assistance recipients age 65 and over (down .2 million recipients).

Trends in Medicaid recipients counts are consistent with data from other sources. For example, the decrease in the total number of AFDC children and adult Medicaid recipients is consistent with the decline in the AFDC cash assistance enrollment. Fiscal Year 1977 AFDC cash assistance enrollment declined 2.6 percent from FY 1976, and 4.0 percent from 1975 (HEW, 1977). The increase in the number of Medicaid disabled recipients from FY 1975 to FY 1977 (15.0 percent and 8.7 percent, respectively) is consistent with the increases of 18.8 percent and 14.0 percent in Medicare disabled recipients for the same periods. While the number of Medicaid aged recipients has remained relatively constant, the number of Medicare aged recipients has been increasing (7.3 percent, FY 1975 to FY 1976, and 5.3 percent, FY 1976 to FY 1977) (HHS, in press).

2.3 Characteristics of Recipients

Table C shows the age, sex, and racial characteristics of Medicaid recipients from FY 1973 through FY 1979 for reporting States.

Medicaid program recipients are:

- Predominantly children, with 47.6 percent in FY 1979 being under 21 years of age;
- Predominantly female, with 65.3 percent female in FY 1979; and
- Predominantly white, with 53.0 percent reported as "white" in FY 1979.[8]

The changes in eligibility groups noted in the preceding section have been reflected in shifts in the characteristics of the recipients. The largest change that has occurred is the 3.6 percent shift from "white" to "other." However, for a variety of reasons, such as State specific privacy regulations, approximately 30 percent of the States fail to report racial data. Hence, the 3.6 percent shift should be reviewed with caution.[9]

The age distribution of Medicaid recipients changed little between FY 1973 and FY 1979. The percent of those 6 to 20 years of age and those age 65 and over decreased, –.4 percent and –.5 percent, respectively. This latter trend is directly opposite that noted by the U.S. Bureau of Census over this same period. According to the Bureau of the Census, those 65 years of age increased 1.2 percent.

[8] The proportion of recipients identified as "other" in Medicaid (47.0 percent in FY 1979) differs significantly from the proportion of persons identified as "other" with incomes at or below the poverty line in the U.S. population. Specifically, the U.S. Bureau of Census estimated that 33.6 percent of those living at or below the poverty line in FY 1979 were of an "other" than white racial category.

[9] A revision of the reporting form implemented in FY 1980 changed the racial reporting categories from "white" and "other" to the five race/ethnic categories mandated by the Office of Management and Budget. Reports for FY 1980 and thereafter will contain the racial data according to the new categories.

2.4 Recipients by Type of Medical Services

Table D shows how many recipients received each of the types of services available under Medicaid. For example, 4.4 million recipients received at least one dental visit in FY 1979. As the data indicate, the use of services in all but three types of service categories increased from FY 1973 through FY 1979. The largest single increase, in terms of the percent of all recipients receiving that service, was in the area of hospital outpatient services: 27.0 percent of all recipients received this type of service in FY 1973, and 34.9 percent received the service by FY 1979.

Approximately 1.9 percent of the 7.9 percent increase observed in outpatient hospital services and 1.9 percent of the 2.1 percent decrease in clinic services may be the result of reporting problems New York experienced prior to FY 1977. New York appears to have had a problem in distinguishing clinic services from outpatient hospital services in years prior to FY 1977. Particularly in FY 1975 and FY 1976, New York reported few expenditures in outpatient hospital services ($2 million and $82 million, respectively) and large expenditures for clinics ($375 and $243 million, respectively). Before and after this two year period, New York reported data similar to the ratio observed in the rest of the States, in which clinic services are only 10 to 15 percent of outpatient hospital expenditures.

The next largest increase in percentage terms was dental services, which increased from 14.9 percent in FY 1973 to 20.5 percent in FY 1979. This increase was primarily due to the increasing number of States that added this optional benefit over these years. The observed 4.2 percent increase between FY 1973 and FY 1979 in use of other practitioner services can be explained by programmatic changes whereby more States recognized more types of non-physician providers.

In terms of relative growth between FY 1973 and FY 1979, outpatient and dental services had less growth than (1) home health services (26.0 percent annual compound

TABLE C
Age, Sex and Race of Recipients For Reporting States: Percent of Total by Fiscal Year: 1973–1979[1, 2]

Fiscal Year	Age					Sex			Race		
	Total	Under 6	6 to 20	21 to 64	65 and Over	Total	Female	Male	Total	White	Other
1973	100.0%	15.7%	32.2%	34.1%	18.0%	100.0%	63.2%	36.8%	N/R	N/R	N/R
1974	100.0	16.1	31.8	34.6	17.5	100.0	65.1	34.9	100.0	56.6	43.4
1975	100.0	15.1	33.0	34.8	17.1	100.0	65.1	34.9	100.0	57.4	42.6
1976	100.0	15.7	33.8	33.8	16.1	100.0	65.1	34.9	100.0	55.9	44.1
1977	100.0	15.7	32.4	34.6	16.5	100.0	64.8	35.2	100.0	57.0	43.0
1978	100.0	15.7	32.6	34.6	16.8	100.0	65.2	34.8	100.0	56.5	43.5
1979	100.0	15.8	31.8	34.9	17.5	100.0	65.3	34.7	100.0	53.0	47.0
Percent Change from FY 1973 to FY 1979		.1	–.4	.8	–.5	—	2.1	–2.1	—	–3.6	3.6

N/R = Not part of the reporting requirement for that fiscal year.
[1] Percentages may not total to 100 percent due to rounding.
[2] The age 65 and over eligibility group is a subset of the recipients age 65 and over receiving Medicaid services. Specifically, some persons over 65 years of age are reported by the States in the permanently and totally disabled category and other eligibility groups.

TABLE D
Recipients by Type of Medical Service: Number and Percent of Total by Fiscal Year: 1973–1979[1]

Fiscal Year	Total[2]	Inpatient Services in General Hospital	Inpatient Services In Mental Hospital	Skilled Nursing Facility Services	ICF Services: Mentally Retarded	ICF Services: All Others	Physician Services	Dental Services	Other Practitioner Services	Outpatient Hospital Services	Clinic Services	Lab & Radiological Services	Home Health Services	Prescribed Drugs	Family Planning Services	Other Care
Number (in Millions)																
1973	20.0	3.3	.1	.7	(Z)	.4	13.3	2.9	1.9	5.3	1.8	4.0	.1	12.1	N/R	3.0
1974	22.0	3.2	.1	.6	(Z)	.6	14.6	3.4	2.3	5.3	1.9	4.1	.1	14.0	N/R	3.9
1975	22.4	3.2	.1	.6	.1	.7	15.4	3.8	2.5	6.2	2.3	4.4	.2	14.0	1.0	3.8
1976	24.7	3.5	.1	.6	.1	.7	15.1	4.2	2.8	7.0	1.9	4.7	.2	15.0	1.1	3.4
1977	23.8	3.7	.1	.6	.1	.7	15.6	4.5	2.9	8.3	1.5	5.4	.4	15.0	1.3	3.2
1978	21.5	3.7	.1	.6	.1	.7	15.3	4.3	3.0	8.3	1.3	5.6	.4	14.7	1.3	2.9
1979	21.5	3.8	.1	.6	.1	.8	15.0	4.4	3.0	7.5	1.5	5.3	.4	14.2	1.2	2.6
Change from FY 1973 to FY 1979		.5	.0	– .1	.0	.4	1.7	1.5	1.1	2.2	– .3	1.3	.3	2.1	.3	– .4
Annual Compound Rate of Growth		2.4%	.0	–2.5%	.0	12.3%	2.0%	7.2%	7.9%	6.0%	–3.0%	4.8%	26.0%	2.7%	2.0%	–2.0%
Percent of Total																
1973	N/A	16.6%	.4%	3.5%	.1%	2.2%	67.7%	14.9%	9.7%	27.0%	9.1%	20.2%	.6%	61.7%	N/R	15.2%
1974	N/A	15.3	.3	3.1	.2	2.7	69.3	16.3	10.7	26.3	8.8	19.5	.6	66.2	N/R	18.4
1975	N/A	15.6	.3	2.8	.2	2.9	69.5	16.9	11.4	27.7	10.1	20.0	.9	63.7	4.7	17.0
1976	N/A	14.9	.3	2.6	.3	3.0	65.8	18.2	12.0	30.5	8.4	21.1	.9	65.7	5.0	15.0
1977	N/A	16.0	.3	2.6	.4	3.2	68.2	19.6	12.5	36.4	6.6	23.5	1.6	65.4	5.8	14.0
1978	N/A	16.8	.3	2.8	.4	3.3	69.0	19.5	13.4	37.3	5.6	25.1	1.6	66.5	5.9	13.0
1979	N/A	17.7	.4	2.8	.4	3.7	69.8	20.5	13.9	34.9	7.0	24.7	1.9	66.0	5.9	12.1
Percent Change from FY 1973 to FY 1979		1.1%	.0%	–.7%	.3%	1.5%	2.1%	5.6%	4.2%	7.9%	–2.1%	4.5%	1.3%	4.3%	.9%	–3.1%

(Z) Indicates a number or percentage less than .05.
N/A = Not Applicable.
N/R = Not part of the reporting requirements for that fiscal year.

[1] Percentages and numbers may not total due to rounding.
[2] This figure represents the total unduplicated recipients for the fiscal year and is *not* the sum of the rows.

rate of growth), and (2) ICF services to other than the mentally retarded (12.3 percent annual compound rate of growth). Dental and other practitioner services showed only 7.2 and 7.9 percent annual compound rate of growth, respectively, over the same time period.

3.0 Payments

3.1 Payments by Basis of Eligibility Groups and Maintenance Assistance Status

Table E shows the distribution of payments by basis of eligibility and maintenance assistance status for FY 1979.

Recipients receiving cash assistance receive more than half of the payments (52.2 percent). Similarly, the age 65 and over (37.5 percent) and permanent and total disability (29.8 percent) recipient groups count for the major share (67.3 percent) of all Medicaid payments. Interestingly, one single group, those age 65 and over receiving only Medicaid, accounts for 27.3 percent of all payments. As Sections 3.3 and 4.0 show, this distribution results primarily not from the absolute number of recipients but from the high unit cost of the long-term care and hospital services used by these recipient groups.

3.2 Trends in Payments Over Time

Total payments under the Medicaid program increased 133.0 percent, from $8.6 billion in FY 1973 to $20.5 billion in FY 1979 (Table F), or more than $2 billion per year. In spite of this rapid growth, the percentage distribution between cash assistance, approximately 52 percent, and Medicaid only, approximately 48 percent, has been highly stable since FY 1973, with the exception of a 3.5 percent shift between FY 1978 and FY 1979. In contrast to this stability, changes in the distribution of payments across eligibility groups by maintenance assistance status has changed significantly since FY 1973. Specifically, two groups, (1) those age 65 and over, and (2) permanently and totally disabled recipients, have accounted for $8.5 billion of the overall $11.9 billion growth between FY 1973 and FY 1979, and by FY 1979 they accounted for 67.2 percent for *all* Medicaid expenditures. In relative terms, the permanently and totally disabled group led all groups, with a 23.2 percent average annual increase in the Medicaid only group, and a 16.5 percent average annual increase in the cash assistance group. The only other group with an average annual increase of that magnitude was the dependent children under 21 cash assistance group, which averaged a 19.1 percent average annual rate of growth.

TABLE E

Payments by Basis of Eligibility and Maintenance Assistance Status: Number and Percent of Total: Fiscal Year 1979

Basis of Eligibility	Total	Money Payment Authorized ("Cash Assistance")	Money Payment Not Authorized ("Medicaid Only")
	Number (in Billions)		
Total	$ 20.5	$10.7	$ 9.7
Age 65 and Over	7.6	2.1	5.6
Blindness	.1	.1	(Z)
Permanent and Total Disability	6.1	3.7	2.4
Dependent Children under 21	2.9	2.4	.4
Adults in Families with Dependent Children	2.8	2.5	.4
Other Title XIX	.9	N/A	.9
	Percent of Total[1]		
Total	100.0%	52.2%	47.4%
Age 65 and Over	37.5	10.2	27.3
Blindness	.5	.5	.2
Permanent and Total Disability	29.8	18.0	11.7
Dependent Children under 21	14.2	11.7	2.0
Adults in Families with Dependent Children	13.8	12.2	2.0
Other Title XIX	4.4	N/A	4.4

(Z) Indicates a number or percentage less than .05.
N/A = Not Applicable.
[1] Percentages and numbers may not total due to rounding.

TABLE F

Payments by Basis of Eligibility and Maintenance Assistance Status: Number and Percent of Total by Fiscal Year: 1973–1979

Fiscal Year[1]	Total For Fiscal Year	Money Payments Authorized ("Cash Assistance")							Money Payments Not Authorized ("Medicaid Only")					
		Total	Age 65 and over	Blindness	Permanent and Total Disability	Dependent Children under 21	Adults in Families with Dependent Children	Other Title XIX Recipients	Total	Age 65 and over	Blindness	Permanent and Total Disability	Dependent Children under 21	Adults in Families with Dependent Children	Other Title XIX Recipients
		Payments (in billions)													
1973	$8.6	$4.7	$1.0	$.0	$1.3	$1.3	$1.3	$.0	$3.9	$2.3	(Z)	$.7	$.4	$.2	$.4
1974	10.0	5.6	1.2	.1	1.6	1.4	1.4	.0	4.3	2.5	(Z)	.8	.4	.3	.4
1975	12.3	6.6	1.4	.1	1.8	1.7	1.7	N/A	5.7	3.3	(Z)	1.0	.5	.3	.6
1976	14.3	7.7	1.5	.1	2.3	2.0	2.0	N/A	6.5	3.7	(Z)	1.3	.5	.3	.7
1977	16.3	9.2	1.9	.1	3.0	2.1	2.2	N/A	7.0	3.9	(Z)	1.5	.4	.3	.9
1978	18.0	10.0	2.0	.1	3.3	2.3	2.3	N/A	8.0	4.4	(Z)	1.8	.4	.3	1.0
1979	20.5	10.7	2.1	.1	3.7	2.4	2.5	N/A	9.7	5.6	(Z)	2.4	.4	.4	.9
Change in Payments FY 1973 to FY 1979		$6.0	$1.1	$.1	$2.3	$1.1	$1.2	N/A	$5.8	$3.3	(Z)	$1.7	$.0	$.4	$.5
Annual Compound Rate of Growth		15.6%	13.6%	13.2%	16.5%	19.1%	11.5%	N/A	16.4%	15.9%	N/A	23.2%	.0%	12.3%	11.5%
		Percent of Total[1]													
1973	100.0%	54.7%	11.4%	.5%	15.4%	12.1%	14.8%	.5%	45.2%	26.0%	.2%	7.9%	4.4%	1.9%	4.8%
1974	100.0	56.3	11.7	.5	16.1	13.1	14.5	.4	43.8	25.2	.2	7.8	4.0	2.6	4.0
1975	100.0	54.0	11.2	.5	14.9	13.3	14.1	N/A	46.1	26.6	.2	8.5	3.4	2.3	5.1
1976	100.0	54.2	10.3	.4	16.1	13.4	14.0	N/A	45.8	25.4	.2	9.0	3.2	2.0	5.0
1977	100.0	56.5	11.6	.4	18.2	12.8	13.5	N/A	43.5	24.2	.2	9.2	2.3	2.0	5.6
1978	100.0	55.7	11.2	.4	18.3	12.9	12.9	N/A	44.4	24.5	.2	10.3	2.0	2.0	5.4
1979	100.0	52.2	10.2	.5	18.0	11.7	12.2	N/A	47.4	27.3	.2	11.7	2.0	2.0	4.4
Percent of Total Change from FY 1973 to FY 1979		−2.5	−1.2	−.0	2.6	−.4	−2.6	−.4	2.2	1.3	.0	3.8	−2.4	−.1	−.4

(Z) Indicates a number or percentage less than .05.
N/A = Not Applicable.
[1]Percentages and numbers may not total due to rounding.

In contrast to these growth groups, payments to adults and dependent children (both cash assistance and Medicaid only) in AFDC families decreased 2.7 percent and 2.8 percent, respectively, as a percent of the total. The Other Title XIX group also decreased .8 percent. The decrease in the Other Title XIX group is primarily a function of the phase out of cash assistance for other Title XIX recipients by FY 1976.

The growth of Medicaid payments can be put in perspective by comparing the growth of prices of medical services, as measured by the medical component of the Consumer Price Index shown in Table G.

In the aggregate, all medical service prices, as measured by the index, have risen 74.1 percent in contrast to the 133.0 percent growth in Medicaid payments over the seven year period. Clearly, this is in sharp contrast to the 1.2 percent annual compound rate of growth noted earlier in the recipient population over this time period.

3.3 Payments by Characteristics of Recipients

Table H contains the age, sex, and race distributions for reporting States between FY 1973 and FY 1979.

TABLE G
Total Medicaid Payments and Medical Component of Consumer Price Index by Fiscal Year: 1973–1979

Fiscal Year	Total Medicaid Vendor Payments (in billions)	Total Payments as a Percent of FY 1973 Base	Medical Component of Consumer Price Index[1]
1973	$8.6	100.0%	100.0%
1974	10.0	116.3	109.3
1975	12.3	143.0	122.4
1976	14.1	164.0	134.1
1977	16.3	199.0	147.0
1978	18.0	209.3	159.3
1979	20.5	233.0	174.1
Percent Change FY 1973 to FY 1979	—	133.0	74.1
Annual Compound Rate of Growth	15.1%	15.1%	9.7%

[1] From Division of National Cost Estimates, Office of Financial and Actuarial Analysis, HCFA.

TABLE H
Percent Distribution of Payments by Age, Sex, and Race of Recipients For Reporting States: Percent of Total by Fiscal Year: 1973–1979[1]

Fiscal Year	Age					Sex			Race		
	Total	Under 6	6 to 20	21 to 64	65 and Over	Total	Female	Male	Total	White	Other
1973	100.0%	6.2%	12.4%	42.8%	36.8%	100.0%	66.6%	33.4%	100.0%	N/R	N/R
1974	100.0	6.0	13.4	41.5	39.1	100.0	69.6	30.4	100.0	69.5	30.5
1975	100.0	5.9	14.0	41.0	39.1	100.0	68.1	31.9	100.0	69.2	30.8
1976	100.0	6.2	14.5	41.4	37.8	100.0	67.8	32.2	100.0	68.2	32.0
1977	100.0	6.2	15.2	42.3	36.4	100.0	67.5	32.5	100.0	69.6	30.4
1978	100.0	6.4	14.0	41.9	37.6	100.0	67.1	32.9	100.0	69.2	30.8
1979	100.0	6.1	13.3	41.6	39.0	100.0	67.4	32.6	100.0	67.7	32.3
Percent Change from FY 1973 to FY 1979		–0.1%	+0.9%	–1.2%	+0.4%	—	+0.8%	–0.8%	—	–1.8%	+1.8%

N/R = Not part of the reporting requirement for that fiscal year.
[1] Percentages may not total to 100 percent due to rounding.

As the data indicate, 80.6 percent of payments are for persons 21 to 64 (41.6 percent in FY 1979) and those 65 and over (39.0 percent in FY 1979). The most notable characteristic of the payment distributions is their stability over time. As Section 4.3 shows, the small changes in the payment distribution in Table H closely parallel shifts in the distribution of recipient characteristics.

3.4 Payments by Type of Service

Table I shows the distribution of payments by type of service. General and mental inpatient hospital services accounted for $6.4 billion in Medicaid payments and 31.4 percent of all payments in FY 1979, while long-term care services, consisting of skilled nursing and ICF services, accounted for $8.7 billion and 42.3 percent of all payments in FY 1979. This 42.3 percent represents a 7.5 percent increase from the 34.8 percent of total payments that long-term care accounted for in FY 1973. What makes this growth even more significant is that the long-term care service group contains the skilled nursing services category which experienced the largest decrease (6.1 percent) as a percent of total payments of any service between FY 1973 and FY 1979. Thus, ICF services accounted for the increase in long-term care expenditures. For a variety of reasons, several States have had difficulty separating ICF service expenditures for the mentally retarded from "all other" ICF service expenditures. Hence, we believe that some of the payments reported for "all other" should be reported under mentally retarded ICF services. Efforts have been and continue to be made to correct this reporting problem.

TABLE I
Payments by Type of Service: Amount and Percent of Total by Fiscal Year: 1973–1979[1]

Fiscal Year	Total	Inpatient Services in General Hospital	Inpatient Services In Mental Hospital	Skilled Nursing Facility Services	ICF Services		Physician Services	Dental Services	Other Practitioner Services	Outpatient Hospital Services	Clinic Services	Lab & Radiological Services	Home Health Services	Prescribed Drugs	Family Planning Services	Other Care
					Mentally Retarded	All Others										
					Amount (in billions)											
1973	8.6	2.7	.3	2.0	.1	.9	.9	.2	.1	.3	.2	.1	(Z)	.6	N/R	.2
1974	10.0	2.9	.4	2.0	.2	1.4	1.1	.3	.1	.3	.3	.1	(Z)	.7	N/R	.2
1975	12.3	3.4	.4	2.4	.3	1.9	1.2	.3	.1	.4	.4	.1	.1	.8	.1	.2
1976	14.3	3.9	.5	2.5	.6	2.2	1.4	.4	.1	.6	.3	.2	.1	1.0	.1	.2
1977	16.3	4.6	.5	2.8	1.0	2.6	1.5	.4	.1	.8	.2	.2	.2	1.0	.1	.2
1978	18.0	5.0	.7	3.1	1.2	3.1	1.6	.4	.1	.8	.2	.2	.2	1.1	.1	.2
1979	20.5	5.6	.8	3.4	1.5	3.8	1.6	.4	.2	.8	.3	.2	.3	1.2	.1	.3
Change from FY 1973 to FY 1979	11.9	2.9	.5	1.4	1.4	2.9	.7	.2	.1	.5	.1	.2	.2	.6	.0	.1
Annual Compound Rate of Growth	15.6%	12.9%	17.7%	9.3%	57.1%	22.2%	10.0%	12.3%	12.3%	17.7%	7.0%	12.3%	20.0%	12.3%	.0	7.0%
					Percent of Total											
1973	100.0%	30.8%	3.4%	22.6%	1.9%	10.3%	10.7%	2.4%	0.9%	3.1%	2.7%	1.2%	0.3%	7.0%	N/R	1.8%
1974	100.0	28.9	4.1	20.0	2.0	13.8	10.8	2.7	1.0	3.2	2.8	1.0	0.3	7.1	N/R	2.1
1975	100.0	27.7	3.3	19.9	2.8	15.2	10.1	2.8	1.0	3.1	3.2	1.0	0.6	6.7	0.5	1.9
1976	100.0	27.6	3.7	17.4	4.2	15.3	9.7	2.7	1.0	3.9	2.4	1.0	0.9	6.7	0.6	1.7
1977	100.0	28.2	3.3	17.3	6.0	16.0	9.2	2.5	0.9	5.2	1.0	1.0	1.1	6.3	0.7	1.4
1978	100.0	27.7	3.6	17.2	6.5	17.4	8.8	2.2	0.8	4.6	1.1	1.0	1.1	6.0	0.6	1.1
1979	100.0	27.6	3.8	16.5	7.4	18.4	8.0	2.1	0.8	4.1	1.3	0.9	1.3	5.9	0.5	1.4
Percent Change from FY 1973 to FY 1979		−3.2	.4	−6.1	5.5	8.1	−2.7	−.3	−.1	1.0	−1.4	−.3	1.0	−1.1	.0	−.4

(Z) Indicates a number or percentage less than .05.
N/R = Not part of the reporting requirement for that reporting year.
Percentages and numbers may not total due to rounding.

This long-term care expenditures growth is put into perspective by Figure 1 which charts the growth of payments for long-term care, inpatient hospital services (both general and mental), and all other Medicaid services. As the figure demonstrates, payments for long-term care services have increased steadily since FY 1973. This increase is a function of the changes in the Medicaid population discussed in Section 2.2, and the utilization changes discussed in Section 5.2 and 5.3. Inpatient hospital services have also increased, but less rapidly. As the figure also shows, the remaining Medicaid services have grown less rapidly than either hospital or long-term care services. For example, physician service and clinic service payments increased $.7 and $.1 billion, respectively. However, as a percent of total payments between FY 1973 and FY 1979, both decreased, 2.7 and 1.4 percent, respectively. In contrast, payments for prescribed drugs grew $.6 billion over this time period, but decreased 1.1 percent as a proportion of total payments.

3.5 Payments Other Than to Medical Vendors

Table J contains medical vendor, Medicare Part B, and Health Maintenance Organizatons (HMOs) payments for Medicaid from Fy 1974 through Fy 1979.

As the data indicate, payments to medical vendors dominate Medicaid payments, and this dominance has increased slightly (.6 percent) between FY 1974 and FY 1979. The $115 million increase in payments to HFCA for Part B premiums is largely a function of the increase in the per person premium rate between FY 1974 (when it was $6.10 per month per person) and FY 1979 (when it reached $8.70 per month per person). Finally, payments for HMOs show that after a growth period from FY 1974 to FY 1976, there has been no increase in HMO payments, even though other data indicate that per person premiums increased since FY 1974. Data from financial reports filed with HCFA suggest that the number of HMO recipients decreased from 314,739 in FY 1978 to 280,542 in December 1980.

4.0 Comparison between Recipient and Payment Distributions and Average Payments Per Recipient

4.1 Comparisons by Basis of Eligibility Groups and Maintenance Assistance Status

Comparisons between recipient and payment distributions for Medicaid, as displayed in Table K for FY 1979, show that a few relatively small eligibility groups consume the majority of Medicaid payments. Specifically, permanently and totally disabled recipients (12.1 percent of total) and those age 65 and over (15.7 percent of total) represent only *27.8 percent of all recipients but account for 67.3 percent of all payments.* In sharp contrast, children and adults in AFDC families, who represent 63.7 percent of all recipients, account for only 28.0 percent of the payments. These differences led directly to the somewhat surprising fact that "Medicaid only" recipients, while comprising only 25.6 percent of the recipient population, account for 47.4 percent of the payments. This situtation is a result of several factors. State and Federal program

TABLE J
Total Medicaid Medical Payments by Type and Fiscal Year: 1974–1979[1, 2]

	Payments (in millions)			
Fiscal Year[3]	Total	Medical Vendor Payments	Payments for Medicare Part B Premiums	Payments to Health Maintenance Organizations
1974	$10,254	$ 9,983	$180	$91
1975	12,615	12,292	212	111
1976	14,522	14,135	251	136
1977	16,661	16,277	260	124
1978	18,374	17,966	282	125
1979	20,900	20,474	295	131
Change FY 1974 to FY 1979	$10,646	$10,491	$115	$40
Annual Compound Rate of Growth	12.6%	12.8%	8.5%	6.2%
	Percent of Total			
1974	100.0%	97.4%	1.8%	.9%
1975	100.0	97.4	1.7	.9
1976	100.0	97.3	1.7	.9
1977	100.0	97.7	1.6	.7
1978	100.0	97.8	1.5	.7
1979	100.0	98.0	1.4	.6
Percent Change FY 1979 to FY 1979	—	.6	–.4	–.3

[1] Percentages and numbers may not total due to rounding.
[2] This total excludes a very small amount of money paid by three States to health insurance plans.
[3] These data were not part of the FY 1973 reporting requirements.

FIGURE 1
Total Medicaid Vendor Payments:
Hospital, Long Term Care,
and All Other Services by Fiscal Year: 1973-1979

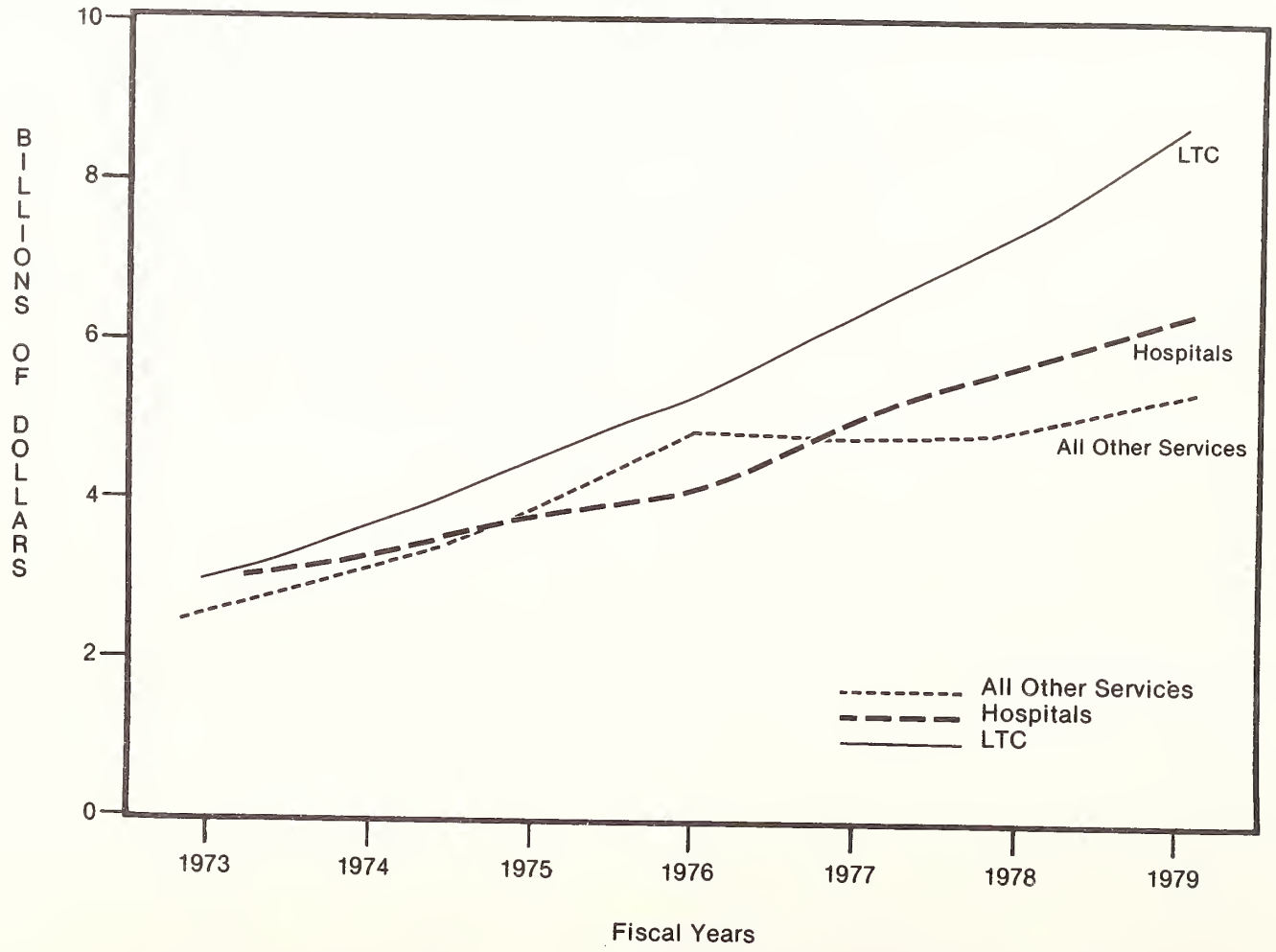

TABLE K
Recipients and Payments by Basis of Eligibility and Maintenance Assistance Status: Percent of Total: Fiscal Year 1979

Basis of Eligibility	Total	Percent Distribution of Recipients: Money Payment Authorized ("Cash Assistance")	Percent Distribution of Recipients: Money Payment Not Authorized ("Medicaid Only")
Total	100.0%	74.4%	25.6%
Age 65 and Over	15.7	9.7	6.0
Blindness	.5	.4	.1
Permanent and Total Disability	12.1	9.3	2.8
Dependent Children under 21	42.3	36.7	5.6
Adults in Families with Dependent Children	21.4	18.1	3.3
Other Title XIX	7.9	N/A	7.9
	Percent Distribution of Payments		
Total	100.0%	52.2%	47.4%
Age 65 and Over	37.5	10.2	27.3
Blindness	.5	.5	.2
Permanent and Total Disability	29.8	18.0	11.7
Dependent Children Under 21	14.2	11.7	2.0
Adults in Families with Dependent Children	13.8	12.2	2.0
Other Title XIX	4.4	N/A	4.4

N/A = Not Applicable.
[1] Percentages may not total to 100 percent due to rounding.

managers generally concur that the primary factor is that many of the "Medicaid Only" recipients become eligible for Medicaid after "spending down" during a costly episode of illness. Hence, they tend to have higher average payments than cash assistance recipients who enter the Medicaid program in a relatively healthy condition.

4.2 Trends Over Time in Payment and Recipient Distribution

Table L elaborates recipient and payment distributions over time. As the table shows, the *relatively expensive groups have been getting more expensive over time.* Specifically, the proportion of permanently and totally disabled among all recipients has increased 2.6 percentage points, from 9.5 to 12.1 percent, but has increased 6.4 percent as a percent of total payments. This trend is directly reflected in the rise in average payment per recipient for this group (see Section 4.5).
Two other groups are noteworthy in terms of the relationship between payment and recipient trends. First, the "Other Title XIX" recipient group has increased (1.2 percent) as a percent of the total, but payments have decreased (−.4 percent). These changes are a direct reflection of the changes in the Medicaid program in Puerto Rico (discussed in Section 6.0 of this report) since Puerto Rican recipients account for the vast majority of Other Title XIX recipients.

4.3 Recipient and Payment Distributions by Selected Characteristics of Recipients

Table M shows the percentage distributions for recipients and payments by age, sex, and race for FY 1973 through FY 1979.

The 65 and over group accounted for only 15.7 percent of the recipients in FY 1979, but accounted for 37.1 percent of the payments. In contrast, those recipients under six years of age accounted for 15.8 percent of the recipients and 6.1 percent of the payments. The sex distributions for recipients and payments were very similiar, but that was not the case for the race distributions, in which other than whites accounted for 47.0 percent of the recipients but 32.3 percent of the payments. This difference is primarily a function of the higher proportion of other than whites in the AFDC program which, because of the high proportion of relatively inexpensive care for children, averaged less per recipient in terms of payments than other groups.

4.4 Average Payments Per Recipient by Basis of Eligibility and Maintenance Assistance Status

Table N displays the average payments per recipient by basis of eligibility group and maintenance assistance status for FY 1979.

TABLE L

Recipients and Payments by Basis of Eligibility and Maintenance Assistance Status: Percent of Total by Fiscal Year: 1973–1979

Fiscal Year[1]	Total For Fiscal Year	Money Payments Authorized ("Cash Assistance")							Money Payments Not Authorized ("Medicaid Only")						
		Total	Age 65 and over	Blindness	Permanent and Total Disability	Dependent Children under 21	Adults in Families with Dependent Children	Other Title XIX Recipient	Total	Age 65 and over	Blindness	Permanent and Total Disability	Dependent Children under 21	Adults in Families with Dependent Children	Other Title XIX Recipients
Percent Distribution of Recipients															
1973	100.0	74.0	11.5	.5	7.5	35.5	18.5	.5	26.0	6.5	.2	2.0	8.5	2.5	7.0
1974	100.0	75.4	11.8	.4	8.6	36.4	17.7	.5	24.5	5.5	.2	1.8	7.7	2.7	6.4
1975	100.0	75.9	11.2	.4	8.1	37.9	18.3	N/A	24.6	5.4	.2	2.2	5.8	2.7	8.1
1976	100.0	74.5	10.1	.4	8.5	36.8	18.6	N/A	25.1	5.3	.2	2.0	6.1	2.4	8.9
1977	100.0	74.4	10.1	.4	9.2	36.5	18.1	N/A	25.6	5.0	.1	2.1	5.9	2.9	9.7
1978	100.0	74.9	9.5	.4	9.5	37.2	18.2	N/A	25.5	5.2	.1	2.2	5.6	3.1	9.1
1979	100.0	74.4	9.7	.4	9.3	36.8	18.1	N/A	25.7	6.0	.1	2.8	5.6	3.3	7.9
Percent of Total Change from FY 1973 to FY 1979		.4	−1.8	−.1	1.8	1.3	−.4	−.5	−.3	−.5	−.1	.8	−2.9	.8	.9
Annual Compound Rate of Growth		1.3%	−1.5%	.0	4.9%	2.0%	.9%	N/A	1.2%	.0	.0	7.0%	7.0%	5.8%	3.3%
Percent Distribution of Payments															
1973	100.0%	54.7%	11.4%	.5%	15.4%	12.1%	14.8%	.7%	45.2%	26.0%	.2%	7.9%	4.4%	1.9%	4.8%
1974	100.0	56.3	11.7	.5	16.1	13.1	14.5	.4	43.8	25.2	.2	7.8	4.0	2.6	4.0
1975	100.0	54.0	11.2	.5	14.9	13.3	14.1	N/A	46.1	26.6	.2	8.5	3.4	2.3	5.1
1976	100.0	54.2	10.3	.4	16.1	13.4	14.0	N/A	45.8	26.4	.2	9.0	3.2	2.0	5.0
1977	100.0	56.5	11.6	.4	18.2	12.8	13.5	N/A	43.5	24.2	.2	9.2	2.3	2.0	5.6
1978	100.0	55.7	11.2	.4	18.3	12.9	12.9	N/A	44.4	24.5	.2	10.3	2.0	2.0	5.4
1979	100.0	52.2	10.2	.5	18.0	11.7	12.2	N/A	47.4	27.3	.2	11.7	2.0	2.0	4.4
Percent of Total Change from FY 1973 to FY 1979		−2.5	−1.2	−.0	2.6	−.4	−2.6	N/A	2.2	1.3	0	3.8	−2.4	−.1	−.4
Annual Compound Rate of Growth		13.6%	13.2%	16.5%	19.1%	10.7%	11.5%	N/A	16.4%	15.9%	.0	23.2%	.0	12.3%	14.5%

N/A = Not Applicable.

[1] Percentages may not total due to rounding.

TABLE M

Recipients and Payments by Age, Sex, and Race of Recipients For Reporting States: Percent of Total by Fiscal Year: 1973–1979[1]

Fiscal Year	Age				Sex			Race		
	Total	Under 6	6 to 20	21 to 64	65 and Over	Total	Female	Male	Total	White	Other
Percent Distribution of Recipients											
1973	100.0%	15.7%	32.2%	34.1%	18.0%	100.0%	63.2%	36.8%	N/R	N/R	N/R
1974	100.0	16.1	31.8	34.6	17.5	100.0	65.1	34.9	100.0	56.6	43.4
1975	100.0	15.1	33.0	34.8	17.1	100.0	65.1	34.9	100.0	57.4	42.6
1976	100.0	15.7	33.8	33.8	16.1	100.0	65.1	34.9	100.0	55.9	44.1
1977	100.0	15.3	32.4	34.6	16.5	100.0	64.8	35.2	100.0	57.0	43.0
1978	100.0	15.5	32.6	34.6	16.8	100.0	65.2	34.8	100.0	56.5	43.5
1979	100.0	15.8	31.8	34.9	17.5	100.0	65.3	34.7	100.0	53.0	47.0
Percent Change from FY 1973 to FY 1979		.1	–.4	.8	–.5	—	2.1	–2.1	—	–3.6	3.6
Percent Distribution of Payments											
1973	100.0%	6.2%	12.4%	42.8%	36.8%	100.0%	66.6%	33.4%	100.0%	N/R	N/R
1974	100.0	6.0	13.4	41.5	39.1	100.0	69.6	30.4	100.0	69.5	30.5
1975	100.0	5.9	14.0	41.0	39.1	100.0	68.1	31.9	100.0	69.2	30.8
1976	100.0	6.2	14.5	41.4	37.8	100.0	67.8	32.2	100.0	68.2	32.0
1977	100.0	6.2	15.2	42.3	36.4	100.0	67.5	32.5	100.0	69.6	30.4
1978	100.0	6.4	14.0	41.9	37.6	100.0	67.1	32.9	100.0	69.2	30.8
1979	100.0	6.1	13.3	41.6	39.0	100.0	67.4	32.6	100.0	67.7	32.3
Percent Change from FY 1973 to FY 1979		−0.1	+0.9	−1.2	+0.4	—	+0.8	−0.8	—	−1.8	+1.8

N/R = Not part of the reporting requirement for that reporting year.
[1] Percentages may not total to 100 percent due to rounding.

TABLE N

Average Expenditures Per Recipient by Basis of Eligibility and Maintenance Assistance Status: Fiscal Year 1979 (in Dollars)

Basis of Eligibility	Total	Maintenance Assistance Status	
		Money Payment Authorized ("Cash Assistance")	Money Payment Not Authorized ("Medicaid Only")
Total	$ 953	$ 631	$1,732
Age 65 and Over	2,311	988	4,308
Blindness	1,318	1,251	1,601
Permanent and Total Disability	2,391	1,850	4,010
Dependent Children under 21	318	304	333
Adults in Families with Dependent Children	580	641	551
Other Title XIX	529	N/A	529

N/A = Not Applicable.

Significant differences occur in the payments across the eligibility and maintenance assistance status groups. Clearly, the most expensive per recipient groups are the Medicaid only age 65 and over, and the permanently and totally disabled groups, which average $4,308 and $4,010 per recipient, respectively. The cash assistance counterparts of these groups average only $988 and $1,850 per recipient. In contrast, adults and children in families with dependent children average only $580 and $318 per recipient, respectively.

4.5 Average Expenditures Per Recipient by Characteristics of Recipients

Table O contains the average expenditures per recipient by age, sex, and race for FY 1973 through FY 1979.

TABLE O
Average Expenditure Per Recipient by Age, Sex, and Race of Recipients by Fiscal Year: 1973–1979[1]

Fiscal Year	Age				Sex	
	Under 6	6 to 20	21 to 64	65 and Over	Female	Male
1973	$147	$142	$463	$790	$385	$331
1974	149	168	479	896	403	363
1975	189	207	575	1,118	502	438
1976	201	217	610	1,185	523	433
1977	259	304	754	1,417	664	588
1978	323	336	926	1,781	799	741
1979	331	358	1,025	1,917	887	808
Change from FY 1973 to FY 1979	$184	$216	$562	$1,127	$502	$477
Annual Compound Rate of Growth	14.1%	16.7%	14.2%	15.9%	14.9%	16.1%

[1] Percentages may not total to 100 percent due to rounding.

As one would anticipate, the age 65 and over group averages nearly twice the per recipient payments of any other group ($1,917). The ratio of the age group payments has remained approximately constant from FY 1973 to FY 1979, with the aged group being approximately five times as expensive as the under 6 group, ans so forth. Similarly, females have accounted for higher payments than have males since FY 1973.

4.6 Trends in Average Payments Per Recipient by Basis of Eligibility Group and Maintenance Assistance Status

Table P contains the average payment per recipient by basis of eligibility and maintenance assistance status from FY 1973 through 1979. Clearly, the variation in average payment per recipient across maintenance assistance groups has been and continues to be significant, with the cash assistance groups averaging only $631 per recipient per year in contrast to the $1,732 average for Medicaid only recipients in FY 1979. As the data indicate, the largest absolute and relative growth in the average annual payment per recipient has been in the Medicaid only age 65 and over and permanently and totally disabled groups. These groups have increased $2,539 and $2,249, respectively, over the FY 1973 through FY 1979 period (an average annual rate of increase of 16.0 and 14.7 percent, respectively). However, due to the relatively slow rate of increase of the Medicaid only adults (5.6 percent) and children (6.0 percent) in families with dependent children, the overall rates of growth of the cash assistance (14.2 percent) and Medicaid only (14.9 percent) groups have been relatively equal.

TABLE P
Average Expenditures Per Recipient by Basis of Eligibility and Maintenance Assistance Status: Number and Percent of Total by Fiscal Year: 1973–1979

	Number (in dollars)													
		Money Payments Authorized ("Cash Assistance")							Money Payments Not Authorized ("Medicaid Only")					
Fiscal Year	Total For Fiscal Year	Total	Age 65 and over	Blind-ness	Perma-nent and Total Disability	Depend-ent Children under 21	Adults in Families with Depend-ent Children	Other Title XIX Recip-ient	Total	Age 65 and over	Blind-ness	Perma-nent and Total Disability	Depend-ent Children under 21	Adults in Families with Depend-ent Children	Other Title XIX Recip-ients
1973	$430	$318	$435	$643	$867	$183	$351	$318	$750	$1,769	$783	$1,761	$235	$399	$286
1974	455	337	462	621	842	175	359	290	796	2,083	821	1,911	235	460	286
1975	549	388	560	761	961	200	415	N/A	1,036	2,750	861	2,416	385	441	316
1976	579	418	600	914	1,095	219	435	N/A	1,048	2,846	970	2,633	333	480	318
1977	685	520	417	1,065	1,364	253	512	N/A	1,148	3,250	1,040	3,109	286	461	391
1978	779	578	909	1,186	1,500	267	548	N/A	1,356	3,667	1,410	3,713	308	481	476
1979	953	631	988	1,251	1,850	304	641	N/A	1,732	4,308	1,601	4,010	333	551	529
Change from FY 1973 to FY 1979	523	313	533	608	983	121	290	N/A	982	2,539	918	2,249	98	152	243
Annual Compound Rate of Growth	14.2%	12.1%	14.7%	11.7%	13.5%	8.9%	10.5%	N/A	14.9%	16.0%	12.7%	14.7%	6.0%	5.6%	10.7%

N/A = Not Applicable.

4.7 Average Payment Per Recipient by Type of Service

Table Q shows the average payment per recipient by type of service for FY 1973 through FY 1979. As one would expect, the average payment for the various types of service varies significantly, from a low of $34 per recipient per year for laboratory and radiological services to a high of $11,952 per recipient per year for ICF mentally retarded services in FY 1979. The variation in the absolute and relative rates of growth have been equally divergent. For example, inpatient services in mental hospitals have increased $4,825, and ICF mentally retarded services have increased $6,262 between FY 1973 and FY 1979, in contrast to an increase of $7 for lab and radiological services over the same time period. In terms of annual rates of growth, two types of services have grown significantly faster than all others, specifically, home health services (22.0 percent), and ICF all other services (15.3 percent). However, four services (inpatient services in mental hospitals, ICF mentally retarded services, outpatient hospital services, and other care) had annual growth rates of approximately 13 percent. The increase in the other care observed between FY 1978 ($69 per recipient) and FY 1979 ($109 per recipient) is largely a function of a reporting problem in New York State. See the detailed tables in appendices A and B for more information about these problems.

5.0 Recipient Utilization Rates

5.1 Interpretation of Recipient Utilization Rates

Health researchers have employed a variety of different types of utilization rates in their study of health care. The most widely used rate has been one that relates the use of services to all persons who could avail themselves of a particular service at risk. These are commonly referred to as population based rates. In the case of Medicaid, the correct population at risk (or the "denominator") would be the number of persons enrolled in the Medicaid program. Unfortunately, until April 1980 when the routine monthly Medicaid report was revised, neither HCFA nor its predecessor agencies collected data at the Federal level on the number of persons enrolled in the Medicaid program. Rather, these agencies collected information on the number of persons who received a particular service (recipients). Hence, it is possible to calculate only recipient utilization rates for the period FY 1973 through FY 1979 and not population based rates.

Two obvious questions arise about recipient utilization rates: (1) how can they be interpreted; and (2) how do they relate to the population based rates? The interpretation of them is straightforward. *Recipient utilization rates* are *measures of the intensity of the use of services among users.* For example, the number of physician visits per recipient decreased from 4.7 per year in FY 1973 to 4.4 in FY 1979. This change can be attributed to changes in the benefits provided by the Medicaid program, service use patterns of the recipients, or any of the numerous other factors that have been shown to induce changes in utilization rates.

The second question is more difficult to answer since only limited data are available at this time. However, preliminary inspection of the new data being received since the revised HCFA-120 was implemented strongly suggests that:

- A high percentage (80 to 85 percent) of those enrolled in Medicaid receive services; therefore, the recipient and population rates are relatively close.
- The recipient and population utilization rates vary significantly across eligibility groups. For example, those age 65 and over have significantly higher utilization rates than the AFDC groups.
- More importantly, recipient and population utilization rates for the various eligibility groups vary significantly across States. We suspect that this is primarily due to: (1) variation in the Medicaid programs across States; (2) differences in spend-down program aspects across the States; and (3) a variety of other factors.

Data on these differences can be found in the *National Medicaid Quarterly Statistics* (forthcoming). Until the relationship is more fully explored, interpretation of recipient utilization rates in relation to population utilization rates should be done cautiously.

TABLE Q
Average Expenditures Per Recipient by Type of Medical Service: Number and Percent of Total by Fiscal Year: 1973–1979

	Amount (in dollars)														
Fiscal Year	Inpatient Services in General Hospital	Inpatient Services In Mental Hospital	Skilled Nursing Facility Services	ICF Services		Physician Services	Dental Services	Other Practitioner Services	Out-patient Hospital Services	Clinic Services	Lab & Radiological Services	Home Health Services	Prescribed Drugs	Family Planning Services	Other Care
				Mentally Retarded	All Others										
1973	$817	$4,532	$2,889	$5,690	$2,067	$70	$71	$43	$51	$132	$27	$227	$50	N/R	$52
1974	891	5,639	3,099	5,205	2,385	74	77	45	58	153	23	230	50	N/R	54
1975	982	6,250	3,939	6,463	2,863	81	93	50	61	174	28	347	59	64	63
1976	1,151	6,934	4,246	7,818	3,219	92	92	54	80	177	30	590	64	76	72
1977	1,257	7,423	4,434	9,168	3,596	98	95	56	106	113	33	496	68	88	68
1978	1,336	9,300	5,031	12,362	4,275	104	91	49	100	153	32	587	74	88	69
1979	1,445	9,357	5,443	11,952	4,878	106	96	52	110	157	34	729	82	90	109
Change from FY 1973 to FY 1979	628	4,825	2,554	6,262	2,811	36	25	9	59	25	7	502	32	34	57
Annual Compound Rate of Growth	9.9%	12.9%	11.1%	13.2%	15.3%	7.2%	5.2%	3.2%	13.7%	2.9%	3.9%	22.0%	8.9%	8.9%	13.1%

N/R = Not part of the reporting requirements for that fiscal year.

The remainder of this section presents data on general inpatient hospital services, skilled nursing home services, ICF services other than for the mentally retarded, physician services, and prescription services. Utilization data on other services were not collected prior to FY 1980. Similarly, the data presented in each section differ from the format presented in other sections. Again, this difference is a function of the reporting form (SRS-NCSS-2082) used prior to FY 1980

5.2 Recipients of General Inpatient Hospital Services

Table R contains the number of recipients of general hospital inpatient services by basis of eligibility for FY 1973 through FY 1979. As the data show, the largest users of general hospital inpatient services are children in families with dependent children (26.0 percent in FY 1979), followed closely by adults in families with dependent children (25.3 percent in FY 1979) and those age 65 and over (23.2 percent in FY 1979). These figures are not surprising in that these groups comprised 42.3, 21.4, and 15.7 percent, respectively, of all Medicaid recipients in FY 1979. As was the case with payments, the permanently and totally disabled comprise only 12.1 percent of Medicaid recipients, but used 19.3 percent of inpatient general hospital services, hence, using relatively more services than other groups.

Another important observation concerns the relative growth of the use of hospital inpatient services by the eligibility groups compared with relative recipient growth. The line in Table R labeled "Annual Compound Rate of Growth" shows the relative growth of each of the groups as a proportion of all Medicaid recipients. As shown, the number of recipients using hospital inpatient services has increased at an annual rate of 2.4 percent in contrast to the growth rate for total Medicaid recipients of only 1.2 percent. The majority of this difference is attributable to the 9.3 percent annual growth rate of use of these services by the permanently and totally disabled group, which grew 6.7 percent in terms of its total number of recipients.

TABLE R
Recipients of General Hospital Inpatient Services by Basis of Eligibility: Number and Percent of Total by Fiscal Year: 1973–1979

	Recipients (in thousands)						
Fiscal Year[1]	Total	Age 65 and over	Blindness	Permanent and Total Disability	Dependent Children Under 21	Adults in Families with Dependent Children	Other Title XIX Recipients[2]
1973	3,256	781	23	426	923	893	211
1974	3,291	759	23	458	952	911	188
1975	3,436	796	21	482	960	928	249
1976	3,545	823	20	560	976	956	211
1977	3,777	832	19	655	993	997	282
1978	3,732	873	17	658	1,010	948	227
1979	3,759	872	19	726	979	952	210
Change from FY 1973 to FY 1979	503	91	–4	300	56	59	–1
Annual Compound Rate of Growth	2.4%	1.9%	–3.0%	9.3%	1.0%	1.1%	(Z)
Recipient Population Annual Compound Rate (from Table B)	1.2%	4.4%	–3.7%	6.7%	.9%	1.1%	2.6%
	Percent of Total						
1973	100.0%	24.0%	.7%	13.1%	28.3%	27.4%	6.5%
1974	100.0	23.1	.7	13.9	28.9	27.7	5.7
1975	100.0	23.2	.6	14.0	27.9	27.0	7.2
1976	100.0	23.2	.6	15.8	27.5	27.0	5.9
1977	100.0	22.0	.5	17.3	26.3	26.4	7.5
1978	100.0	23.4	.5	17.6	27.1	25.4	6.1
1979	100.0	23.2	.5	19.3	26.0	25.3	5.6
Percent of Total Change from FY 1973 to FY 1979	—	–.8	–.2	6.2	–2.3	–2.1	–.9

(Z) Indicates a number or percentage less than .05.
[1] Percentages and numbers may not total due to rounding.
[2] Variations over time in this group are primarily due to variation in reporting from Puerto Rico. See Section 6.2 for details.

5.3 Recipients and Days of Care for Skilled Nursing Home Services

Table S contains the reported number of recipients, total days of care, and average days per recipient for skilled nursing home care from FY 1973 through FY 1979. As the data show, there has been a significant decline, averaging 2.0 percent per year, in the total days of care, from 94.4 million in FY 1973 to 83.9 million in FY 1979. The number of recipients has also fallen at a slightly faster rate than days of care (3.0 percent per year). As the data also show, the consumption of skilled nursing services is dominated by the age 65 and over group which consumed 64.9 of the 83.9 million days of skilled nursing home care paid for by Medicaid in FY 1979. The next largest user is the permanently and totally disabled group, which consumed only 14.2 percent of all skilled nursing home care. Together, these two groups used 97.1 percent of all days of nursing home care. Although there has been a slow decline in the total days of care, the average days of care per recipient increased by some 11 days since FY 1973. The increase in average days of care is the only increase noted in the use of nursing home services.

5.4 Recipients and Days of Intermediate Care Facility Services Other Than for the Mentally Retarded

In contrast to the decline in the use of skilled nursing services, there has been a steady increase in the use of care provided in the imtermediate care facilities other than for the mentally retarded (Table T). The number of days of care provided in such facilities has increased from 70.9 million in FY 1973 to 147.1 million in FY 1979, for an annual rate of increase of 12.9 percent. As was the case with skilled nursing care services, the age 65 and over group dominates the consumption of these services, using 114.8 million of the 147.1 million days of care (77.8 percent) in FY 1979. Further, as was the case with skilled nursing services, the average days of care received has increased some 31 days per year since FY 1973, up to an average of 242 days per recipient in FY 1979. The increases in recipient utilization far exceeded the growth rates for this group as a percent of the Medicaid recipient population noted in Section 2.2. Hence, the percent of Medicaid recipients age 65 and over in ICFs other than for the mentally retarded has increased significantly since FY 1973.

TABLE S
Recipients and Days of Skilled Nursing Home Care by Basis of Eligibility and Fiscal Year: 1973–1979

	Basis of Eligibility Groups[1]								
	Total			Age 65 and Over			Permanently and Totally Disabled		
Fiscal Year	Number of Recipients (in thousands)	Total Days of Care (in millions)	Average Days Per Recipient	Number of Recipients (in thousands)	Total Days of Care (in millions)	Average Days Per Recipient	Number of Recipients (in thousands)	Total Days of Care (in millions)	Average Days Per Recipient
1973	520	94.4	182	410	75.9	185	90	15.5	172
1974	454	85.0	187	363	68.6	189	79	14.5	184
1975	409	78.1	191	334	65.0	194	65	11.8	179
1976	455	84.4	186	365	69.0	189	73	13.0	178
1977	512	98.8	193	417	75.3	181	86	14.8	173
1978	517	90.2	195	418	73.9	187	90	15.3	170
1979	435	83.9	193	338	64.9	192	76	14.2	188
Change from FY 1973 to FY 1979	– 85	–10.5	11	– 72	–11.0	7	– 14	–1.3	16
Annual Compound Rate of Growth	–3.0%	– 2.0%	1.0%	–3.1%	– 2.5%	.6%	–2.7%	–1.5%	1.5%

[1] Data on other basis of eligibility groups not shown in the table are not available.

TABLE T
Recipients and Days of Intermediate Care Facility Services Other than fo the Mentally Retarded by Basis of Eligibility and Fiscal Year: 1973–1979

	Basis of Eligibility Groups[1]								
	Total			Age 65 and Over			Permanently and Totally Disabled		
Fiscal Year	Number of Recipients (in thousands)	Total Days of Care (in millions)	Average Days Per Recipient	Number of Recipients (in thousands)	Total Days of Care (in millions)	Average Days Per Recipient	Number of Recipients (in thousands)	Total Days of Care (in millions)	Average Days Per Recipient
1973	335.8	70.9	211	246.7	51.7	210	88.8	19.2	216
1974	465.3	108.2	232	333.0	77.3	232	132.3	30.9	233
1975	503.6	121.6	241	382.2	95.2	249	121.4	26.4	217
1976	580.1	142.4	245	438.8	108.5	247	141.3	33.9	239
1977	597.3	139.9	234	462.4	108.3	234	134.9	31.6	234
1978	613.6	139.8	238	464.1	104.1	234	149.5	35.7	239
1979	600.9	147.1	242	473.7	114.8	240	127.2	32.3	253
Change from FY 1973 to FY 1979	265.1	76.2	31	277.0	63.1	30	38.4	13.1	37
Annual Compound Rate of Growth	10.2%	12.9%	2.3%	11.5%	14.3%	2.3%	6.2%	9.1%	1.1%

5.5 Recipients and Visits for Physicians Services

Table U contains the average number of reported physician visits per recipient by eligibility group. There has been a steady decline in physician visits per Medicaid recipient (1.1 percent average decrease per year). The largest single decline has been in the age 65 and over group (6.0 percent average decrease per year). It is also noteworthy that the trend for blind recipients since FY 1975 has been in the direction of a steady increase, from 6.0 visits per year in FY 1975 to 6.8 visits per year in FY 1979. The use of physician visits by the remaining eligibility groups has remained relatively constant since FY 1973.[10]

[10] Fluctuations in the "Other Title XIX" group is primarily attributable to fluctuations in the reports from Puerto Rico. See Section 6.2 for details.

5.6 Average Number of Prescriptions Per Recipient

Table V contains the average number of prescriptions per recipient by eligibility group from FY 1973 through FY 1979. In contrast to the decline in physician visits, the average number of prescriptions per recipient has increased from 10.8 per recipient in FY 1973 to 12.4 in FY 1979. The largest increase per recipient has been in the age 65 and over group (5.4 prescriptions per recipient increase) and the permanently and totally disabled group (4.8 prescriptions per recipient increase). Relatively small gains have been registered in adults in families with dependent children groups (.4 per recipient).

TABLE U
Average Number of Visits Per Recipient For Physicians' Services By Basis of Eligibility and Fiscal Year: 1973–1979[1]

	Visits Per Recipient						
Fiscal Year	Total	Age 65 and over	Blindness	Permanent and Total Disability	Dependent Children Under 21	Adults in Families with Dependent Children	Other Title XIX Recipients
1973	4.7	7.6	7.4	9.2	3.8	6.1	3.9
1974	4.6	6.6	6.2	8.0	3.8	4.7	4.1
1975	4.8	6.2	6.0	8.0	4.0	5.0	4.7
1976	4.9	6.4	6.1	8.5	4.2	6.5	4.3
1977	4.7	5.6	6.4	8.3	4.0	6.2	4.4
1978	4.6	5.3	6.6	8.4	4.0	5.9	4.1
1979	4.4	5.3	6.8	8.1	3.9	6.0	3.6
Change from FY 1973 to FY 1979	–.3	–2.3	–.6	–1.1	+.1	–.1	–.3

[1] Numbers may not total to 100 percent due to rounding.

TABLE V
Average Number of Prescriptions Per Recipient Eligibility Group and Fiscal Year: 1973–1979

	Prescriptions Per Recipient						
Fiscal Year	Total	Age 65 and over	Blindness	Permanent and Total Disability	Dependent Children Under 21	Adults in Families with Dependent Children	Other Title XIX Recipients
1973	10.8	20.6	19.6	17.4	4.1	9.1	31.0
1974	10.4	18.9	19.7	17.2	4.3	8.9	27.0
1975	11.1	21.1	16.7	19.3	4.2	9.1	14.9
1976	12.1	22.7	18.5	21.2	4.8	8.7	12.4
1977	12.3	22.8	20.3	21.7	4.3	8.9	15.6
1978	12.4	25.2	20.4	21.9	4.7	8.9	13.5
1979	12.4	26.0	20.3	22.2	4.5	9.1	12.9
Change from FY 1973 to FY 1979	1.6	5.4	.7	4.8	.4	.0	–18.1[1]
Annual Compound Rate of Growth	2.3%	3.3%	1.5%	3.3%	1.5%	.0%	–13.5%

[1] This decrease is primarily a function of suspected reporting problems experienced by two Medicaid jurisdictions in FY 1973 and FY 1974.

6.0 Special Topics

The data provided through the Medicaid statistical system provide information on several topics of special importance. The following four sections examine four such topics.

6.1 Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) to Medicaid Children

Table W presents data on EPSDT services from FY 1975 through FY 1979.

TABLE W
Early and Periodic Screening, Diagnosis, and Treatment Services: Total Children Screened, Referred, and Total Payments by Fiscal Year: 1975–1979[1]

	Number (in millions)		
Fiscal Year	Children Screened	Children Screened Found to have Referrable Conditions	Total Payments for Screening Services
1975	1.8	.9	$33.7
1976	2.0	1.0	46.8
1977	2.1	1.1	51.9
1978	2.0	1.0	47.6
1979	2.0	1.0	48.4
Change from FY 1975 to FY 1979	.2	.1	14.7
Annual Compound Rate of Growth	3.6%	3.5%	9.5%

[1] Reporting of these services prior to FY 1975 is not available.

As the data indicate, there has been little change in the use of EPSDT services since FY 1975. Approximately two million children have been screened per year, with half of them found to have referrable conditions. The payments for these services have also remained relatively unchanged since FY 1976 in spite of the increase of the cost of such medical services as measured by the medical component of the CPI noted in Section 3.2.

6.2 The Puerto Rican Medicaid Program[11]

In FY 1979, the Puerto Rican Medicaid program served 6.6 percent of all Medicaid program recipients, or approximately 1.4 million, almost half of the Island's 2.9 million inhabitants. However, the program spends only .4 percent of all Medicaid payments ($83 million in FY 1979). This contrast between payments and recipients results from a variety of factors. The chief factor is that Congress "capped" the Federal contribution to the program at $30 million per year since its beginning in FY 1972. This cap, and the nature of the Puerto Rican situation, has resulted in a unique Medicaid program.

There is no freedom of choice for Puerto Rican Medicaid recipients. All Medicaid services are provided directly through the Commonwealth and Municipal Government Health Facilities. There are no private physicians, laboratories, home health centers, diagnostic facilities, and so forth, participating in the Medicaid program. As a result, the program has a simplified cost accounting and reimbursement system based on the two categories of care: inpatient and outpatient services.

The Medicaid program staff manually produces the required HCFA statistical reports. Manual reports are also produced concerning service costs, type of services used, length of inpatient stays, and so forth. Under an agreement with HCFA, claims processing is done by the Puerto Rican Medicaid staff by processing a 1 percent sample of outpatient claims. Data obtained from analysis of the 1 percent sample are projected to the universe and, after determining the proportion subject to the Federal share, are added to the total system facility costs to arrive at the amount of Federal Financial Participation to be claimed. Due to this unique health care and claims processing system, billing form variables are significantly different from those on the mainland. These form differences, and the nature of the sampling/claims payment process, make it very difficult for the Puerto Rican Medicaid program staff to prepare the statistical (and for that matter, all) reports for HCFA. However, they do prepare the reports by interpolating from their categories to those on the Federal reports as best they are able.

These difficulties in constructing the statistical reports have led to considerable fluctuations, from year to year, in data for Puerto Rico. For example, Table X presents recipient counts as reported by Puerto Rico, and Table Y presents the corresponding payment data. Examination of these tables leads to two main conclusions. First, there is a marked shift of recipients and dollars across eligibility groups between FY 1974 and FY 1975; approximately 300,000 recipients "moved" to the Other Title XIX Medicaid Only group in a single year. Secondly, there is a concentration of the Puerto Rican Medicaid program in the Medicaid Only groups. The Puerto Rican program reports approximately 90 percent of the Medicaid Only recipients in contrast to the 47 percent observed in the mainland programs. In particular, approximately 50 percent of the Puerto Rican program is concentrated in the Other Title XIX category. This results in the Puerto Rican program accounting for a significant portion of the recipients in the Other Title XIX Medicaid Only group for the entire Medicaid program. For example, .7 million of the 1.7 million recipients in the Other Title XIX group reported in FY 1979 were from Puerto Rico. Hence, the average cost, changes over time, use of services, and other data reported in previous sections for the Other Title XIX group are heavily influenced by the reports and nature of the Puerto Rican program. For example, the average cost per recipient in Puerto Rico in FY 1979 was $68. This amount contrasts sharply with the $958 for the program as a whole.

In summary, the Puerto Rican program reporting has a significant effect on the data presented for the Other Title XIX group. Interested persons may use the data in Tables X and Y to remove this effect from preceding tables if they feel this is warranted.

[11] This section borrows heavily from a report being developed by Aileen Pagan, "The Puerto Rican Medicaid Program and Its Implications for Changes in the Mainland Medicaid Program," Medicaid Program Data Branch.

TABLE X

Puerto Rican Recipients by Basis of Eligibility and Maintenance Assistance Status: Number and Percent of Total by Fiscal Year: 1973–1979

Fiscal Year[1]	Total For Fiscal Year	Money Payments Authorized ("Cash Assistance")							Money Payments Not Authorized ("Medicaid Only")						
		Total	Age 65 and over	Blindness	Permanent and Total Disability	Dependent Children under 21	Adults in Families with Dependent Children	Other Title XIX Recipient	Total	Age 65 and over	Blindness	Permanent and Total Disability	Dependent Children under 21	Adults in Families with Dependent Children	Other Title XIX Recipients
						Number (in millions)									
1973	1.7	.2	(Z)	(Z)	(Z)	.1	(Z)	N/A	1.5	.1	(Z)	(Z)	.8	.1	.6
1974	1.8	.2	(Z)	(Z)	(Z)	.1	.1	N/A	1.6	(Z)	(Z)	(Z)	.8	.2	.6
1975	1.7	.2	(Z)	(Z)	(Z)	.1	.1	N/A	1.4	(Z)	(Z)	(Z)	.3	.2	.9
1976	1.5	.1	(Z)	(Z)	(Z)	.1	(Z)	N/A	1.3	(Z)	(Z)	(Z)	.4	.2	.7
1977	1.7	.2	(Z)	(Z)	(Z)	.1	.1	N/A	1.5	(Z)	(Z)	(Z)	.3	.2	.9
1978	1.6	.2	(Z)	(Z)	(Z)	.1	(Z)	N/A	1.4	(Z)	(Z)	(Z)	.3	.2	.8
1979	1.4	.2	(Z)	(Z)	(Z)	.1	.1	N/A	1.2	.0	(Z)	(Z)	.3	.2	.7
Change from FY 1973 to FY 1979	– .3	.0	N/A	N/A	N/A	.0	N/A	N/A	– .3	–.1	N/A	N/A	– .5	.1	.1
Annual Compound Rate of Growth	–3.3%	.0%	N/A	N/A	N/A	.0%	N/A	N/A	–3.5%	N/A	N/A	N/A	–15.0%	12.3%	2.6%
						Percent of Total[1]									
1973	100.0	10.7	.9	.1	.8	7.1	1.8	N/A	89.6	4.3	.3	1.9	45.4	4.7	33.0
1974	100.0	10.0	.2	.1	.9	5.8	4.5	N/A	88.8	.8	.1	1.4	43.9	9.6	33.0
1975	100.0	13.1	.4	(Z)	.3	8.5	3.9	N/A	86.9	1.8	.2	.9	19.7	11.4	52.9
1976	100.0	9.1	.2	(Z)	.4	5.9	2.6	N/A	90.9	1.4	.1	1.3	25.2	11.5	51.4
1977	100.0	12.5	.2	.1	.9	7.8	3.5	N/A	87.3	.7	.1	2.2	17.1	14.6	52.6
1978	100.0	11.4	.1	.1	.9	6.8	3.5	N/A	88.8	.7	.1	6.2	19.7	13.9	48.2
1979	100.0	12.5	.0	(Z)	1.0	6.9	4.6	N/A	87.6	.0	(Z)	.2	23.1	16.7	47.6
Percent of Total Change from FY 1973 to FY 1979		1.8	–.9	N/A	.2	–.2	2.8	N/A	–2.0	–4.3	N/A	–1.7	–22.3	12.0	14.6

(Z) Indicates a number or percentage less than .05.
N/A = Not Applicable.
[1] Percentages and numbers may not total due to rounding.

6.3 Sterilizations

Table Z shows the number of reported sterilizations for which Federal Financial Participation was claimed by fiscal year, sex, and procedure. These data are collected on a special report known as the HCFA-80. Because of significant non-reporting by such States as New York, these data should be viewed with caution and as a statement of only what has been reported, not necessarily what has been performed. A forthcoming paper will examine sterilizations under Medicaid in detail and impute the missing data to get totals more representative of actual sterilizations under Medicaid (Berlucchi, *et al*).

6.4 Payment for "State Only" Recipients and Services

The States have the option of paying for services and recipients not eligible for Federal Financial Participation. Table AA shows the payments that have been reported for such services and recipients since the first full year of reporting, FY 1976, by type of service.

California and New York accounted for the vast majority of "State Only" payments (52.6 percent and 27.5 percent, respectively, in FY 1979).[12]

In contrast to the 12.8 percent annual growth rate of payments, State Only payments have increased only at a 3.0 percent annual rate of growth. The distribution across types of services also is dramatically different from that observed in Section 3.4 for Federally matched payments. In particular, State Only payments for long-term care were less than 1 percent of total payments (in FY 1979).

[12] The other States reporting State only expenditures during this period were Alaska, Colorado, Georgia, Hawaii, Illinois, Louisiana, Maine, Maryland, Massachusetts, Michigan, Montana, North Carolina, North Dakota, Oregon, Rhode Island, South Dakota, Utah, West Virginia, and Wisconsin.

TABLE Y

Puerto Rican Payments by Basis of Eligibility and Maintenance Assistance Status: Number and Percent of Total by Fiscal Year: 1973–1979

Fiscal Year[1]	Total For Fiscal Year	Money Payments Authorized ("Cash Assistance")							Money Payments Not Authorized ("Medicaid Only")						
		Total	Age 65 and over	Blindness	Permanent and Total Disability	Dependent Children under 21	Adults in Families with Dependent Children	Other Title XIX Recipient	Total	Age 65 and over	Blindness	Permanent and Total Disability	Dependent Children under 21	Adults in Families with Dependent Children	Other Title XIX Recipients
	Number (in millions)														
1973	95.2	11.6	1.0	(Z)	1.6	6.7	2.3	N/A	83.5	5.3	.1	4.3	39.6	6.7	27.5
1974	100.3	11.9	.2	(Z)	1.7	7.4	2.6	N/A	88.4	1.4	.1	4.7	43.6	7.4	31.2
1975	113.1	11.0	.4	(Z)	.9	6.2	3.6	N/A	102.1	2.8	.1	2.9	19.8	6.5	70.0
1976	94.0	9.2	.3	(Z)	.7	5.8	2.3	N/A	84.8	2.2	.1	2.4	16.4	5.5	58.3
1977	94.8	11.2	.4	(Z)	1.3	4.7	4.8	N/A	83.6	1.9	(Z)	2.9	14.8	13.8	50.3
1978	97.5	10.9	.1	.1	1.5	4.6	4.5	N/A	86.6	1.0	.1	2.9	17.1	16.3	49.2
1979	83.0	9.2	.0	.1	1.3	4.0	3.8	N/A	73.8	.0	(Z)	2.5	13.8	14.6	42.8
Change from FY 1973 to FY 1979	−12.2	−2.4	−1.0	N/A	− .3	−1.7	1.5	N/A	−9.7	−5.3	N/A	−1.8	25.8	7.9	15.3
Annual Compound Rate of Growth	− 2.1%	−3.7%	N/A	N/A	−3.4%	−8.1%	8.8%	N/A	−2.0	N/A	N/A	−8.5	−16.2	13.8%	7.6%
	Percent of Total[1]														
1973	100.0	12.4	1.1	.1	1.6	7.1	2.5	N/A	87.8	5.6	.1	4.5	41.6	7.1	28.9
1974	100.0	12.0	.2	.1	1.7	7.4	2.6	N/A	88.1	1.4	.1	4.6	43.5	7.4	31.1
1975	100.0	9.8	.3	(Z)	.8	5.5	3.2	N/A	90.2	2.4	.1	2.5	17.6	5.7	61.9
1976	100.0	9.6	.3	(Z)	.7	6.2	2.4	N/A	90.2	2.3	.1	2.5	17.4	5.8	62.0
1977	100.0	11.9	.4	.1	1.4	5.0	5.0	N/A	88.1	2.0	.1	3.1	15.6	14.5	52.9
1978	100.0	11.2	.1	.1	1.6	4.7	4.7	N/A	89.0	.9	.1	3.0	17.5	17.0	50.5
1979	100.0	11.1	.0	(Z)	1.6	4.8	4.6	N/A	88.9	.0	(Z)	3.0	16.6	17.6	51.6
Percent of Total Change from FY 1973 FY 1979		−1.3	−1.1	N/A	.0	−2.3	2.1	N/A	1.1	−5.6	N/A	−1.5	−25.0	10.5	22.7

(Z) Indicates a number or percentage less than .05.
N/A = Not Applicable.
[1] Percentages and numbers may not total due to rounding.

TABLE Z

Total Number of Reported Sterilizations Under Medicaid By Sex and Type of Procedure by Fiscal Year: 1975–1979

Fiscal Year	Total Sterilizations	Sex and Type of Procedure						
		Males			Females			
		Total	Vasectomy	Other	Total	Tubal Ligation	Hysterectomy	Other
1975[1]	33,805	1,773	1,197	565	32,032	26,685	4,259	1,088
1976	67,575	2,709	2,684	25	64,866	57,546	3,652	3,668
1977	63,679	2,781	2,761	20	60,898	57,189	379	3,330
1978	65,775	2,787	2,763	24	62,988	57,979	1,311	3,698
1979	73,746	N/A	N/R	N/R	N/A	N/R	N/R	N/R

N/R = Not part of the reporting requirements for that fiscal year.
N/A = Not Available.
[1] Data cover only last six months of 1975.

TABLE AA
Reported Payments for State Only Recipients and Services by Type of Service and Fiscal Year: 1976–1979[1]

	Payments (in millions)			
Fiscal Year	Total	Inpatient Hospital Services	Long-Term Care Services	All Other Services
1976	$867.3	$314.2	$ 8.5	$544.6
1977	792.2	331.5	11.4	449.3
1978	873.3	417.1	11.0	445.2
1979	950.2	434.3	9.2	506.7
Change FY 1976 to FY 1979	$ 89.9	$120.1	$ .7	$–37.9
Annual Compound Rate of Growth	3.0%	11.4%	2.6%	–3.5%

[1] Data are not available prior to FY 1976.

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